

NOMPUMELELO D.R.C. MISSION HOSPITAL PEDDIE CISKEI PHYSIOTHERAPY DEPT.

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Peddie is situated close to the national road between King William's Town and Grahamstown. The Hospital is about a mile from Peddie, also on the national road, as one travels from Peddie to Grahamstown. The African population in the district total approximately 42 000. At present there are about plus-minus 800 Europeans residing in this district. The hospital itself has a bed accommodation of 220 including a Chronic Division of 72 beds. In 1974 we shall have two full-time medical officers, and two other doctors in private practice, also helping at the hospital. One of the private practitioners is an African. In addition we have two European sisters, 13 qualified African sisters, a physiotherapist, an occupational therapist, a secretary, a lady in-charge of laundry work and the kitchen, a work's manager, and a spiritual social-worker in our service. Those listed after the African sisters are all at present Europeans. Besides these mentioned, one should never forget that we are being assisted by male and female nurses, office staff, labourers and women working on the domestic side.

Adjacent to the hospital premises, is an old age home which also accommodates a variety of physically handicapped Xhosa people, run by the Ciskei Government. A few clinics are also supervised from the hospital and are used to serve the outlying areas of the district. In 1966 with several orthopaedic cases being transferred from urban hospitals to our chronic division, the doctors soon realised the need of a physiotherapist to start a physiotherapy department. In January, 1967, I started the work officially, with no equipment and a very small space. At first we had a space of 20 ft. by 10 ft. in which we were expected to perform all our physiotherapy treatments. The occupational therapist could only confine her activities to ward work, and packing space was sadly lacking.

At that stage it was difficult to obtain a Government subsidy for the erection of a physiotherapy and occupational department. Both the Mission and Hospital Boards gave permission for us to launch a fund for this much needed project. With fervent prayer, a profound faith in God, and hard work we set about this task. We accepted this as a challenge and despite certain obstacles success was achieved. Several public bodies, churches and individuals were approached for donations and support in other ways, such as advice in planning the whole project. Generous financial support from the Peddie Red Cross Society, the Mine Labour Organisation (or the National Recruitment Corporation), the S.A. National Council for the Care of Cripples, certain sections of the Dutch Reformed Church, and interested individuals enabled us to erect a prefabricated building, to accommodate facilities for physiotherapy and occupational therapy.

The physical medicine department consists of the following rooms: an office for the physiotherapist; office for the occupational therapist, a cubical for electrotherapy treatments, a gymnasium for exercises size (35 ft. x 20 ft.), a large hall for occupational therapy, and other facilities such a recreation and practising of



A view from the air of the hospital, with the Old Age Home in the background. Physiotherapy Department on the right.

walking (size 75 ft. x 30 ft.) and lately a small compartment which serves as a kiosk and a kitchen for the occupational therapist have been added.

The donations were sufficient to purchase the necessary equipment for our treatments. Among others we have the following equipment available: A short wave diathermy apparatus, a treatment unit for electrical muscle stimulation, an ultra-sound machine, two infrared lamps, various types of walking aids, including long parallel-bars, a stationary bicycle, a self-constructed suspension apparatus, with slings, ropes, straps and springs; two exercise mats, medicine balls and weights. A second-hand short wave diathermy apparatus was recently donated to the hospital. It was also possible to purchase the essential equipment for occupational therapy treatment. Even after seven years our work is still mainly financed by the kind donors who have helped us in the past. Although Mission Hospitals are subsidised a hundred percent by the Department of State Health, this is only in theory, as far as it affects us.

The type of patients being treated at this hospital can be divided into three main categories:

1. Patients who are treated for a short period only.
2. Long-term cases.
3. Patients who remain in our chronic section either for a very long time or permanently.

To enable the physiotherapist to pay more attention to the acute and subacute conditions, we have taught medical orderlies to carry out some basic and simple routine treatments, under very strict supervision. If this method is not applied, it will mean that the condition of these patients will just deteriorate. If emphasis is not laid on the maintenance of paraplegics, haemiplegics, quadraplegics and conditions of multiple arthritis, it will be an insult to the advanced surgical, medical physical treatments given either locally or in other urban centres.

Among the orthopaedic and neurological group, the following conditions occur quite frequently: Fractures (in some cases complicated fractures); joint and muscle injuries; T.B. Spine; different patterns of paralysis resulting from spinal and cerebral conditions; and burns. Burns occur often among young children, especially in the winter, when they seem to fall into the fire or pull a pot of boiling water all over them. Haemiplegia result mainly from cerebral vascular haemorrhage or head injuries. During the main holiday periods, such



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as Christmas, stick fights are the order of the day and a few of them finish up with very severe injuries.

Our orthopaedic surgery is usually carried out at the Frere hospital in East London or at the Mount Coke Methodist Mission Hospital near King William's Town. Quite soon after the operation has been performed, and the surgeon is satisfied that there are no further complications, they are transferred back to us for treatment and rehabilitation.

Malnutrition and vitamin deficiencies, do cause partial paralysis, general weakness, muscle inco-ordination and postural deformities. As far as we can determine, the reasons for malnutrition occurring are due to ignorance of hygienic living and the type of food that they should eat and in addition to this of course, there is the problem of large families and finance. However, the Department of State Health has sponsored the hospital to launch a campaign of health education and family planning. To ensure success, co-operation from the whole community is vitally essential.

Bronchiectasis, atelectasis, emphysema, lung abscesses and chronic bronchitis seem to be the most commonly referred for Physiotherapy treatment, among lung conditions. Owing to several reasons, lung T.B. is still a great problem. After the T.B. drugs have been administered for a while, some of these cases are referred for postural drainage and breathing exercises, should there also be additional lung complications.

During the last few years, there have been several conditions of T.B. meningitis. Only a few have recovered sufficiently to lead a normal life again. If only these patients would be brought to the hospital in the early stages, more fatalities could be prevented.

We can confirm the findings revealed in an earlier publication of this journal, that incorrect breathing is a very real problem. This appears to be strange, as many of them walk long distances every day of their lives. After persevering for a while, lateral costal breathing improves tremendously in many patients, however, diaphragmatic breathing is not so easy and some do not ever manage to do it properly. The stabbed chest, as seen on numerous occasions in urban hospitals, is a rarity in our area. I can only recall a few haemopneumothorax cases being referred to me during the last twelve months.

The main problem about breathing exercises is that one has no guarantee that the patient does them on his or her own. Although it is incredible, we have discovered that once they discover the benefit of strengthening, mobilising, functional and walking exercises, that they are inspired to carry them out more regularly, than is the case with breathing exercises. All of us are fully aware that exercises given during a physiotherapy treatment period, in the majority of conditions, is not enough. Recovery will always depend to a large extent on the co-operation of the patients themselves.

Generally, the occupational therapist and I do our departmental work in the morning and undertake the ward work in the afternoon. If a patient should require treatment more than once daily, our programme is flexible enough to make provision for this.

A paraplegic sports club has been started, and has been running for more than two years. Approximately 14 patients in the chronic division are trained in field events such as shot put, javelin, an discus. Table tennis has also proved to be popular with a few of them. Our patients in the general hospital who stay for long periods, are also encouraged to participate in the sporting events.

The occupational therapist, who also has to have African assistants under her, is responsible for teaching actions of daily living, educational games for the children, various forms of functional assessment and training, recreation and hand work. Under recreation is

included, film shows, sports and the encouraging of reading books from our small library. The kitchen provides an excellent opportunity for the teaching of cooking, ironing and other domestic activities.

One of the patients residing permanently in the chronic division of our hospital, a quadraplegic, with very little muscular function in both upper limbs, is studying for his junior certificate. Years ago an injury while playing rugby, resulted in a lesion at the seventh cervical vertebrae. After treatment at the Conradie Hospital, he was transferred to Peddie, on account of his family not being in a position to look after him at home. Our occupational therapist made an adjustment for him to cope with an electrically operated typewriter, enabling him to do all his written work. It is hoped that he will further his education as far as possible. The O.T. Department is also responsible for making adjustments enabling patients with permanent disabilities to brush their own teeth, shaving themselves, handling eating utensils to feed themselves and even to write with an ordinary pen.

Those who stay here for a considerable length of time or permanently in the chronic division, can take part in a miniature sheltered employment scheme. Among others they take part in sewing, knitting, weaving of rugwool mats, leather work such as purses and Bible covers, bottle brushes and sheep skin seat covers for motor cars. The latter seems to be immensely popular and at the moment we have a long waiting list of orders. They use off-cut sheep skins, which are obtained from a tannery.

In the two departments, our purpose is to approach the patient as a whole. By this we mean that we do help him with his spiritual, social, economic, psychological as well as his physical problems. It has happened in the past that faith in Christ has acted as a solid foundation for partial or complete recovery. Where necessary, we try to assist long-term patients with their financial problems, mainly derived from donated funds. If one bears in mind that some patients are in hospital for long periods, with young children still attending school, and a mother having to keep the pot boiling on her own, financial and other burdens can impede effective rehabilitation. We assist those who are permanently disabled to apply for special radio listener's licences.

Employment of the disabled, is of course an exceedingly great problem, especially in the home lands. After long negotiations we successfully placed two rehabilitated patients with the hand craft centre, at Sada, near Queenstown. Some of our patients who recovered either fully or nearly fully, have been re-employed by their previous employers, however, they were only helped in view of the fact that they could manage with complete independence. There is a factory near King William's Town, where the management has taken steps to employ some physically handicapped Africans, but this is only a drop in the proverbial ocean.

From time to time we have come across children who are disabled, either on account of congenital conditions, or by subsequent injury or disease. Several of these children are educable. Unfortunately, because of lack of being able to get to school independently, they are denied the opportunities of receiving a normal education. The only school for the physically disabled in the Trans- and Ciskei, is the Ikweni Lokusa School in Umtata. Their waiting list is so long, that there is no justification for making any application. Only recently I have been informed of a school being planned for the Ciskei in the near future.

In dealing with African patients, I have discovered that to make one's treatment more effective, it is essential to follow certain principles. For instance, a basic knowledge of the local African language does help to

bridge the gap, and initiates the confidence of the patient in the doctor, nurse, physio- or occupational therapist. Europeans who are permanently employed in our group of mission hospitals, are required to follow a short course in Xhosa. A basic knowledge in African customs is indeed a valuable asset. One soon finds that there is a difference between many Africans who come from the homelands, and those who have been born or have lived for a long time in the cities. On many of the uneducated Bantu and to a lesser extent the educated Bantu, the witch doctor seems to have a strong influence. According to certain experts there are signs of this declining gradually. I have knowledge of a few of our patients, having only been treated partially successfully in past, who have gone to a witch doctor with disastrous consequences. Fortunately this has not happened very frequently and despite what some people might say, you do get enough gratitude to make work at these hospitals more than worth while.

We are permitted to treat Europeans in the district as out-patients, provided they can pay a minimal fee. I have had several referred to me over the last few years.

We do not pretend to be a show window for physical medicine treatment in Homeland hospitals and in fact I think we can still learn a tremendous amount. With limited resources at our disposal in the beginning, we have tried to build up the work and we can now continue on a solidly laid foundation. All of us on the medical and administrative staff, count it a privilege to assist with the spiritual and other activities in our spare time. The work is not always a path of roses, but there are more than sufficient times for rejoicing and rewards. If there were no challenges to be overcome, life would in fact be dull and uninteresting. After all, if one is a Christian, one will not seek reward on earth for any thing, but continue to serve.

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Dr. Basil V. Schulze, principal Physician-in-charge of Medical Rehabilitation Services in Natal and Senior Clinical Lecturer and Head of the sub-Department of Physical Medicine in the Faculty of Medicine of the University of Natal in Durban has been appointed to the newly created Chair of Medical Rehabilitation at the University of Durban-Westville. This chair is the first of its kind in the country.

Professor Schulze was born in East London and educated in the Eastern Province. He obtained the M.B., Ch.B. degrees at the University of Cape Town in 1945 and after completing a year as an intern in Medicine and Surgery at the King Edward VIII Hospital in Durban, he left to further his studies in Europe.

He spent six years in England doing specialist study in Physical Medicine and Rehabilitation first at the University of Bristol and then at the University of London. Subsequently he was on the staff of Guys Hospital and St. Thomas' Hospital in London and in 1950 was appointed Consultant to the Windsor Group of Hospitals in the London region of the British National Health Service.

In 1953 he returned to South Africa and settled in Durban where he has headed Natal's provincial medical rehabilitation service since its inception.

Professor Schulze who has travelled extensively in Europe, Africa and the Far East has undertaken many advisory assignments in his field of medicine. He recently has devoted much of his attention to problems of medical rehabilitation in Southern Africa and following requests for his advice made to the Republic's Department of Foreign Affairs by the Governments of Swaziland and Lesotho and by the Chief of the Portuguese Military Medical Services in Mocambique, he has visited these countries within the last year to assist with local needs.

He has published papers on different aspects of his subject and recently contributed the chapter on "Myalgia and Arthritis" in the text-book "Clinical Medicine in Africans in Southern Africa," published in London in 1973 by Livingstone.

He was intimately involved in the establishment of the first and, until very recently, the only training school for black physiotherapists in Southern Africa. This, among his many other activities, he has fostered since its inception in 1964.

Due almost exclusively to his determination, the present diploma course was replaced as from the beginning of 1974 by a four year course leading to the degree B.Sc. (Physiotherapy). This will provide the first and only University Physiotherapy degree training available exclusively to blacks on the African continent.